AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING 00 COMPLETER		
		155417	B. WING		05/20/2011
	PROVIDER OR SUPPLIER		1100 N	ADDRESS, CITY, STATE, ZIP CODE GARDNER AVE SBURG, IN47170	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
F0000	Complaint INC Complaint INC Substantiated. deficiencies re allegations are F328. Survey date: 5 Facility number Provider number	Federal/state lated to the cited at F272 and /20/11 er: 000421 per: 155417 100288340 Jennie Bartelt, RN pe:	F0000	This Plan of Correction constitute written allegation of compliance for the deficiencies cited. However, submission of Plan of Correction is not an admission that a deficiency exor that one was cited correctly This Plan of Correction is submitted to meet requirement established by state and federalaw. Hickory Creek at Scottsburg desires this Plan of Correction be considered the facility's Allegation of Compliance. Compliance is effective on June 19, 2011.	this ists ts al

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000421

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	155417	A. BUILDING	00	05/20/2011
			B. WING	ET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUPPLIER		ı	N GARDNER AVE	
HICKOR'	Y CREEK AT SCOT	TSBURG	sco	TTSBURG, IN47170	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
IAG		LSC IDENTIF FING INFORMATION)	IAU		DATE
	Sample: 3				
	These deficiencies reaccordance with 410	eflect state findings cited in DIAC 16.2.			
F0272 SS=D	The facility must of periodically a com	/11 by Suzanne Williams, RN onduct initially and prehensive, accurate, oducible assessment of nctional capacity.			
	assessment of a re RAI specified by th must include at lea Identification and of Customary routine Cognitive patterns Communication; Vision; Mood and behavior Psychosocial well- Physical functionin Continence; Disease diagnosis Dental and nutritio Skin conditions; Activity pursuit; Medications; Special treatments Discharge potentia	demographic information; e; or patterns; being; ng and structural problems; and health conditions; anal status; es and procedures;			
	protocols; and	tional assessment the resident assessment participation in assessment.			
	Based on recor		F0272	F 272	05/27/2011
	interview, the	facility failed to		It is the policy of this fac	ility
		dent was assessed		to conduct initially and periodically a	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		OO COMPI			(X3) DATE SURVEY COMPLETED		
		155417	- 1	LDING		05/20/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			1100 N GARDNER AVE			
	Y CREEK AT SCOT	TSBURG		SCOTTSBURG, IN47170			
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	` ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
IAG		ntravenous insertion		IAG	comprehensive, accurate	+	
	site and the am	nount of fluids			standardized reproducib	le	
	infused for 1 o				assessment of each reside	ent's	
		ed to intravenous			functional capacity,		
					including assessments		
	infusion in a sa	ample of 3.			related to intravenous		
	(Resident M)				insertion sites and the		
					amount of fluids infused.	,	
	Findings inclu	de:			1) 1171	(-)	
The clinical record for Resident M				1.) What corrective action will be accomplished for a	` ′		
				residents found to have b			
	was reviewed on 5/20/11 at 11:50				affected by the deficient	een	
	a.m.				practice?		
	••••				practice.		
	Nurse's Notes	for 5/14/11 at 7:30			The survey was conducte	ed	
		, "[Name of Nurse			on May 20, 2011; howeve	er,	
	•	ame to facility to			the IV was discontinued	on	
	_	·			May 18, 2011 and the site		
	-	ident]. N.O. [new			not been used for IV flui		
		ne sulfate 0.5 - 1.0			since that time. Nurses N	l	
		ymbol for hours]			for this resident indicate		
	-	ed]. IV site to L [left]			5-20-11 that there were n		
	FA [forearm].	Flushes with ease,			signs of infiltration at the		
	blood return."				time. This resident has n		
					had any other IV therapy since that time.	y	
	Nurse's Notes	on 5/15/11 at 12:00			since that time.		
		I morphine sulfate			An in-service was held or	n	
	•	red as ordered, and			5-20-11 for RNs and LPN		
		s assessed with "			the facility policy and		
					procedure regarding IV		
	- ·	o] S/S [signs and			therapy and assessments	that	
	symptoms] of	infiltration or			should occur when IV		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M A. BUI		onstruction 00	(X3) DATE SURVEY COMPLETED
		155417	B. WIN			05/20/2011
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG				1100 N	ADDRESS, CITY, STATE, ZIP CODE GARDNER AVE SBURG, IN47170	
	SUMMARY S' (EACH DEFICIENCE REGULATORY OR infection noted infection infection infection infection infection infection infiltration to I infiltration to I infiltration infiltrat	TSBURG TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) I" indicated the IV site again, about 12 hours I1 at 12:30 p.m. with and dry [symbol for on or infiltration" indicated the IV site again, about 24 hours I1 at 12:53 p.m. as In as I2:53 p.m. as In as I2:53 p.m. as In as I3:53 p.m. as I3:50 p.m. as I4:51 p.m. as I5:51 p.m. as I6:51 p.m. as I7:51 p.m. as I8:51 p.m. as		1100 N	GARDNER AVE SBURG, IN47170 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADERICIENCY) therapy is being administered, IV documentation and the fit to be used for documentation of IV therapy. 2.) How other residents having the potential to be affected by the same deficient what corrective action(s) be taken. No other residents were affected. There were no other residents receiving IV therapy in the facility at time of survey. In the future, if the DON should find that intravent therapy is not being administered, assessed, of documented as per facility policy, she will intervene immediately to make sur that the resident is being	orm ation cient and will the tous or ty
	a.m., indicated and infusing at	for 5/16/11 at 2:00 l, "IV fluids started t 100 cc/hr via LFA IV cannula]"			cared for and that appropriate documentat is in place to support the administration of the IV therapy. Once that is do she will re-train any RN	ion ne,

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ĺ	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED COMPLETED			
		155417	- 1	BUILDING 05/20/2011			
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	GARDNER AVE		
	Y CREEK AT SCOT	TSBURG		1	SBURG, IN47170		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
IAG		for 5/17/11 at 7:40		IAG	LPN who has been invol		
	a.m. indicated				in the identified		
					noncompliance regardin	g the	
		ifuse at 100 cc per			facility policy and		
	hour.				procedures for IV therap	oy.	
					Progressive disciplinary		
	The next Nurs	e's Note related to the			action will be followed fo	or	
	IV site was 5/1	17/11 at 12:00 p.m.			continued noncomplianc	e.	
	and indicated,	"Res. IV site					
infiltrated. Noticeable pooling to L FA & hand" Physician's orders					3.) What measures will be	e put	
					into place or what system	ic	
were received to discontinue and				changes will be made to			
					ensure that the deficient		
	relocate the IV	·			practice does not recur?		
	Dogumentation	n failed to indicate			The IV documentation for	orm	
					includes places to docum		
		nent of the IV site			every 8 hour site monitor	l l	
		cannula was removed			for signs and symptoms	·	
	or the area affe	ected by the			complications, IV fluid		
	infiltration to t	the left arm.			order, the rate of infusio	n,	
					and the amount of fluids		
	Nurse's Notes	for 5/17/11 at 2:00			infused each shift. The		
		I, "IV inserted into R			nurses have been instruc	eted	
	[right] AC [an	<i>'</i>			that they are to documen	ıt in	
		-			the nurses' progress note		
		IVF [intravenous			any unusual observation	s or	
	fluids] cont. as	s ordered"			complications that they		
					observe or assess whenev	/er	
	The next Nurs	e's Note related to the			IV therapy is being		
	IV site was 5/1	18/11 at 3:45 a.m. and			administered.		
	indicated, "N.0	O. D/C [discontinue]					
	, and the second	elated to] infiltration.			The "Medication Pass	_	
		initiation.			Intake" form was revised	d to	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		INSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155417	B. WIN			05/20/2011
	NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG			1100 N	ADDRESS, CITY, STATE, ZIP CODE GARDNER AVE SBURG, IN47170	
(X4) ID PREFIX TAG	Documentation failed to indicate assessed from the right arm unhours later. Documentation failed to indicate assessed from the right arm unhours later. Documentation failed to indicate fluids administrated to indicate descent with an insignature on the a.m. shift for 5 other documentation on the Treatment the continuous documentation amount of IV for the Resident II.	morning" In in Nurse's Notes ate the IV site was time of insertion into antil more than 12 In in the Nurse's Notes ate an amount of IV atered to the resident. Record for May ("D5 1/2 NS ath) 20 mEq of KCL (nitial for a nurse's ate 10:00 p.m. to 6:00 /16 to 5/17/11. No atation was indicated ant Record related to infusion. The failed to indicate the fluids infused.		1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEPICIENCY) reflect the amount of fluir received via IV each shift. This amount will be transcribed from the MA each day onto the resident individual Intake Log. The Director of Nursing designee will audit the 24 report and the focus charat least 5 days per week. She finds that a resident I new IV orders, she will ensure the IV orders incl. IV fluid order, the rate of infusion, and the amount fluids infused per shift at monitoring for signs and symptoms of complication. She will review the documentation on the form and care plan to make suthat it is complete and the the appropriate assessments have been not as required. If any issues identified during the review the Director of Nursing were the Director of Nursing wer	ds t. AR ats or a-hr. rting If has ude f tof ad ns. rms are at ents oted are dews, vill
	_	ake Log failed to			follow through as indicat in question #2.	ea
	indicate the an				in question #2.	
	received intrav	enously.				
					4.) How the corrective	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			A. BUILDING 00			(X3) DATE SURVEY COMPLETED
		155417	B. WIN			05/20/2011
NAME OF I	PROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP CODE	-
HICKUD	Y CREEK AT SCOT	TSRURG		1	GARDNER AVE SBURG, IN47170	
					DDONG, INTTITU	0/5
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	The resident's	care plan, dated			action(s) will be monitore	ed to
	5/14/11, indica	nted, "Problem: IV			ensure the deficient pract	ice
	<u> </u>	[] hand" with undated			will not recur, i.e., what	
	, , =	filtrated - move to L			quality assurance program	m
		al." Interventions			will be put into place?	
		were not limited to,			The Director of Nursing	or
	ŕ	ite for changes: i.e.			designee will bring the	
	redness, draina	C			results of the audits (QA	
					audit tool # 272-1) to the	
swellingMonitor intake and					monthly QA & A Comm	ittee
outputDocument IV administration on flow sheet/MAR				meeting.		
	[Medication A	dministration			The committee will revie	w
	Record]."				the results and provide	
					recommendations for an	· I
	The facility's "	IV Policy and			process identified as need improvement. This will be	~
	Procedures" w	as provided by the			followed up by the Direc	
	MDS (Minimu	ım Data Set)			of Nursing or designee, v	
	Coordinator or	n 5/20/11 at 1:30 p.m.			will report on the status	1
	Review of the	-			these recommendations a	
		n IV Site" indicated,			the next QA & A Commi	ttee
		be monitored at least			meeting.	
		rs [hours] by the IV				
	*	Step 1. Observe the			While the process of the	
		ns of complications			review of the 24-hr. repo	
	_	-			and the focus charting by	y tne
		e following: Edema -			Director of Nursing or designee, will continue or	, an
	Swelling is an				ongoing basis, the	ן מוו
		anching - Blanching			documented audits will	
		n of infiltration;			continue through the nex	at 90
	Redness - Red	ness in the area of the			days. At that time, the Q	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155417		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/20/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN47170			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
1AG	tip of the cather vessel may be phlebitis and/o Moisture or exsite: This may indicateInfilt the area." Reverse for "Continuous of Fluids/Med "Monitorthe infusion" During this time, the Mindicated the fragmentation was and Intake and indicated the indicated	eter and along the an indication of or infiltration; audates at insertion attrationInfection of iew of the procedure as IV Administration ications" indicated, e site throughout the During interview at MDS Coordinator facility did not use a low Sheet to record of fluids but the lould be on the MAR I Output Record. She information was not the resident's records.	TAG	A Committee may term the documented audits i facility has reached 100' compliance. Date of Compliance 5-2'	inate if the %	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155417		(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING (X3) DATE SU COMPLET 05/20/20:			ETED		
	PROVIDER OR SUPPLIER Y CREEK AT SCOT		B. WIN	1100 N	ADDRESS, CITY, STATE, ZIP CODE GARDNER AVE 'SBURG, IN47170		<u> </u>
F0328 SS=D	SUMMARY S' (EACH DEFICIENCE REGULATORY OR The facility must exproper treatment as special services: Injections; Parenteral and ent Colostomy, ureterd Tracheostomy care; Foot care; and Prostheses. Based on obset and record reverse for an intrinfusion related the venous according of fluids admining tresidents reviet intravenous i	ratement of deficiencies cy must be perceded by full LSC IDENTIFYING INFORMATION) Insure that residents receive and care for the following teral fluids; deteral fluids; dete	F0	ID PREFIX TAG	F 328 It is the policy of this fact to ensure residents receive proper treatment and car for special services, inclumanagement of care for intravenous infusions and assessment of the venous access site and amount of fluid administered. 1.) What corrective action will be accomplished for the residents found to have be affected by the deficient practice? No other residents were affected. There were no other residents receiving IV therapy in the facility at the second point of the second points.	dity re re ding d	(X5) COMPLETION DATE 05/27/2011
	, , ,	ght side wearing a The resident's left			time of survey.	unc	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				X2) MULTIPLE CONSTRUCTION (X3) DATE SURV COMPLETED A. BUILDING		
		155417	B. WIN			05/20/2011
	PROVIDER OR SUPPLIER		· ·	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN47170		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	arm was lying	across the right arm,			Nurses Notes for this	
	with the palm	of the right hand			resident indicate on 5-20	
	visible and slig	ghtly puffy.			that there were no signs	l l
					infiltration. This resident	
	During intervi	ew on 5/20/11 at			not had any other IV the	rapy
		N #4 indicated the			since that time.	
	<i>'</i>	I fluids which the			An in-service was held or	n
family had decided to discontinue due to infiltration. LPN #4					5-20-11 for RNs and LPN	ls on
					the facility policy and	
		recalled the resident			procedure regarding IV	_
		cess sites - one in the			therapy and assessments	that
					should occur when IV	
		one in the right			therapy is being administered, IV	
	antecubital spa				documentation and the fo	orm
	indicated both	sites had infiltrated.			to be used for documenta	
		7.10.0.14.4			of IV therapy.	
		ew on 5/20/11 at				
		esident M's two			2.) How other residents	
		cated the family did			having the potential to be	
	not wish for th	e resident to have IV			affected by the same defic	
	fluids again, si	nce the IV sites had			practice will be identified what corrective action(s)	
	infiltrated and	the resident's arms			be taken.	wiii
	had become pu	ıffy.			oc tuncin	
					No other residents were	
	During intervi	ew on 5/20/11 at			affected.	
	12:50 p.m., the	e Director of Nursing			There are no residents	
	(DON) indicat				receiving IV therapy in t	he
	` ′	arted the first IV in			facility at this time.	
		eft hand, and she, the			In the future !fthe DON	.
		ted the IV in the right			In the future, if the DON should find that intraven	
	, maa star	to the firm the fight			Should lind that intraven	lous

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		COMPLETE			(X3) DATE SURVEY COMPLETED	
		155417	A. BUILDING B. WING			05/20/2011
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER			1	GARDNER AVE	
	Y CREEK AT SCOT	TSBURG		SCOTT	SBURG, IN47170	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	, i	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
1710		first IV infiltrated.		ing	therapy is not being	DATE
	arm when the	ingt i v inimitated.			administered, assessed, o	r
	The clinical re	cord for Resident M			documented as per facili	
		on 5/20/11 at 11:50			policy, she will intervene	
		011 3/20/11 at 11.30			immediately to make sur	e
	a.m.				that the resident is being	
					cared for and that	
	Nurse's Notes for 5/14/11 at 7:30				appropriate documentat	
p.m. indicated, "[Name of Nurse Practitioner] came to facility to					is in place to support the	
					administration of the IV	
check res. [resident]. N.O. [new				therapy. Once that is do	· I	
	order] morphine sulfate 0.5 - 1.0				she will re-train any RN LPN who has been involved	
	_ ^	ymbol for hours]			in the identified	veu
		ed]. IV site to L [left]			noncompliance regarding	n tha
	_	Flushes with ease,			facility policy and	g the
	blood return."	Trushes with case,			procedures for IV therap	,v.
	biood return.				Progressive disciplinary	
					action will be followed fo	r
		on 5/15/11 at 12:00			continued noncomplianc	e.
	a.m., indicated	l morphine sulfate				
	was administer	red as ordered, and				
	the IV site was	s assessed with "				
	symbol for no	o] S/S [signs and				
	symptoms] of	-			3.) What measures will be	^ I I
	infection noted				into place or what system	ic
		····			changes will be made to	
	Nurse's Notes	indicated the IV site			ensure that the deficient	
					practice does not recur?	
		gain on 5/15/11 at			The IV documentation for	.rm
		h "Site clean and			includes places to docum	
	• - •	or no] S/S infection or			every 8 hour site monitor	
	infiltration"				for signs and symptoms	~ I

li i					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
		155417	B. WIN			05/20/2011
NAME OF I	PROVIDER OR SUPPLIER		!	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER			1100 N	GARDNER AVE	
HICKOR	Y CREEK AT SCOT	TSBURG		SCOTT	SBURG, IN47170	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
IAG	REGULATORY OR	LSC IDENTIFFING INFORMATION)		IAG	complications, IV fluid	DATE
				order, the rate of infusion	n	
		indicated the IV site			and the amount of fluids	···•
	was assessed a	again on 5/16/11 at			infused each shift. The	
	12:53 p.m. as	"[symbol for no]			nurses have been instruc	ted
	S/S infection of	or infiltration to IV			that they are to documen	
	site."				the nurses' progress note	
					any unusual observation	
	 Nurse's Notes	for 5/16/11 at 10:00			complications that they	
	p.m., indicated				observe or assess whenev	er
	_	=			IV therapy is being	
	attending physician] here to visit &				administered.	
		05 1/2 [5% dextrose				
	solution with	1/2 strength normal			The "Medication Pass	
	saline] [symbo	ol for with] 20 mEq			Intake" form was revised	l to
	[milliequivale	nts] of KCl			reflect the amount of flui	ds
	potassium ch	loride] at 100 cc hr			received via IV each shift	t .
	1 -1	[continuous]"			This amount will be	
		[••••••••••			transcribed from the MA	
	Nurgala Notas	for 5/16/11 at 2:00			each day onto the resider	nts
					individual Intake Log.	
	1	l, "IV fluids started				
	1	t 100 cc/hr via LFA			The Director of Nursing	
	#22 [gauge of	IV cannula]"			designee will audit the 24	
					report and the focus char	-
	Nurse's Notes	for 5/17/11 at 7:40			at least 5 days per week.	
	a.m. indicated	the IV fluids			new IV orders, she will	uas
		nfuse at 100 cc per			ensure the IV orders incl	ude
	hour.	2000 at 100 00 por			IV fluid order, the rate o	
	iloui.				infusion, and the amount	
		1 NT 4 1 4 1 4 4			fluids infused per shift an	
		e's Note related to the			monitoring for signs and	
	IV site was 5/	17/11 at 12:00 p.m.			symptoms of complication	
	L				1 Jampieuro	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTR		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		00	COMPL		
	155417		B. WING 05/20.			05/20/2	2011	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE					
HICKORY CREEK AT SCOTTSBURG					SBURG, IN47170			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	` `	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΤΕ	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)	+	TAG			DATE	
	and indicated,	•			She will review the			
	infiltrated. N	oticeable pooling to L			documentation on the fo			
	FA & hand'	" Physician's orders			and care plan to make sure			
	were received	to discontinue and			that it is complete and th			
	relocate the IV				the appropriate assessme	ents		
	Telocate the 1	v :			& the results of those			
					assessments have been n			
	Documentation	on failed to indicate			as required. If any issues			
	further assessment of the IV site where the IV cannula was removed or the area affected by the				identified during the rev			
					the Director of Nursing v			
					follow through as indica	ted		
	infiltration to	•			in question #2.			
	initiation to the left arm.							
	Nurse's Notes for 5/17/11 at 2:00 p.m., indicated, "IV inserted into R [right] AC [antecubital] X 2 attempts 22 g. IVF [intravenous fluids] cont. as ordered" The next Nurse's Note related to the IV site was 5/18/11 at 3:45 a.m. and indicated, "N.O. D/C [discontinue] IV R AC r/t [related to] infiltration. Hold IVF until morning"				4.) How the corrective			
					action(s) will be monitore	ed to		
					ensure the deficient pract			
					will not recur, i.e., what	ice		
					quality assurance progra	1111		
					will be put into place?	ni.		
					wiii ve pui inio piuce:			
					The Director of Nursing	or		
					designee will bring the			
					results of the audits (QA			
					audit tool # 272-1) to the			
					monthly QA & A Comm			
					meeting.			
					g -			
	Documentation in Nurse's Notes				The committee will revie	e W		
	failed to indicate the IV site was		the results and provide					
	assessed from time of insertion into the right arm until more than 12				recommendations for an	\mathbf{v}		
					process identified as nee	-		
					improvement. This will h	_		
	hours later.				followed up by the Direc			
					10110 wear up by the Direc			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/20/2011			
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN47170				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	PROVIDER OR SUPPLIER Y CREEK AT SCOTTSBURG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL				of Nursing or designee, will report on the status these recommendations the next QA & A Commimeeting. While the process of the review of the 24-hr. reported and the focus charting be Director of Nursing or designee, will continue of ongoing basis, the documented audits will continue through the next days. At that time, the QA Committee may terming the documented audits if facility has reached 100% compliance. Date of Compliance 5-27	of at at ittee ort y the n an A & nate f the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417		LDING	NSTRUCTION 00	(X3) DATE SUR COMPLETI 05/20/201	LETED	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE			
HICKORY CREEK AT SCOTTSBURG				1	GARDNER AVE SBURG, IN47170			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID			(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		OMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	redness, drainage, pain,							
	outputDocu	onitor intake and						
	1 *	on flow sheet/MAR						
	[Medication Administration Record]."							
	11000101.							
	During intervi	ew on 5/20/11 at 1:40						
	p.m., LPN #6 indicated Resident M's first IV that infiltrated was in							
	the left forearm, and she pointed to							
	area just above the wrist. LPN #6							
	indicated when the IV infiltrated on the left, the resident had a pooled pocket of fluid under the forearm, and the left hand was swollen. She indicated the area was not cool or warm to the touch. LPN #6 indicated when the IV on the right arm infiltrated, the swelling was mostly in the right hand, and the right arm was slightly swollen. She indicated when she noticed the							
		ourniquet used to						
		•						
	start the IV was lying unfastened under the resident's arm up under the sleeve of her gown.							
		- 6						
	The facility's	'IV Policy and						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
155417			B. WING				05/20/2011	
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STAT	E, ZIP CODE		
HICKORY CREEK AT SCOTTSBURG					GARDNER AVE BBURG, IN47170	0		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECT			(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		E	COMPLETION DATE
1710		vas provided by the		1110				Ditte
	MDS (Minima	•						
	`	n 5/20/11 at 1:30 p.m.						
		procedure for						
		n IV Site" indicated,						
		be monitored at least						
	l	rs [hours] by the IV						
	l	= - ·						
	trained nurseStep 1. Observe the IV site for signs of complications							
	described in the following: Edema -							
	Swelling is an indication of							
	infiltration; Blanching - Blanching							
	is an indication of infiltration;							
		lness in the area of the						
	tip of the cath	eter and along the						
	1 ^	an indication of						
	phlebitis and/o							
	Moisture or exudates at insertion							
	site: This may							
	indicateInfiltrationInfection of							
	the area." Rev	iew of the procedure						
	for "Continuous IV Administration							
	of Fluids/Med	ications" indicated,						
		e site throughout the						
	infusion" [Ouring interview at						
		MDS Coordinator						
		Cacility did not use a						
	separate IV Fl	ow Sheet to record						
	_	of fluids but the						
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	 KOK011	Facility II	D: 000421	If continuation sh	eet Pa	ge 16 of 17

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155417		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	COMPI	(X3) DATE SURVEY COMPLETED 05/20/2011			
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SCOTTSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN47170					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE				
	information w and Intake and indicated the i	ould be on the MAR d Output Record. She information was not he resident's records.				DATE		